H. PROVIDER ISSUE RESOLUTION

The MHP recognizes that at times providers may disagree with the MHP over an administrative or fiscal issue and will be happy to work with them to solve the problem. There is both an informal and formal Provider Problem Resolution Process for providers who have concerns or complaints about the MHP.

Informal Process

Providers are encouraged to communicate any concerns to the Program Monitor or designee. The Program Monitor or designee shall respond in an objective and timely manner, attempting through direct contact with the provider to resolve the issue. When issues are not resolved to the provider's satisfaction informally, a formal process is available. A copy of materials will be sent to the County Mental Health QI Unit.

If the provider is not satisfied with the result of the informal process or at any time, the formal process below is available:

Formal Provider Problem Resolution Process

1. Providers shall submit in writing any unresolved concerns (except appeals of billing disallowances) to the MH Services Contracts Manager or designee, using the Formal Complaint by Provider form located in the Quick Reference Section of this handbook.
2. Written narration shall include all relevant data, as well as attachment of any documents, which support the provider's issue(s).
3. Formal complaint (except appeals of billing disallowances) shall be submitted within 90 calendar days of original attempt to resolve issue(s) informally.
4. The Contracts Manager or designee shall have 60 calendar days from the receipt of the written complaint to inform the provider in writing of the decision, using the Formal Response to Complaint section of the Formal Complaint by Provider form.
5. The written response from the Contracts Manager or designee shall include a statement of the reason(s) for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.
6. Formal Provider Problem Resolution documentation is to be directed to:

Mental Health Services Contracts Manager
P O Box 85524
San Diego, CA 92186-5524
Mail Stop: P531-K

7. A copy of all complaint materials shall be sent to the County Mental Health QI Unit.
8. For appeal of billing disallowances, submit a detailed letter of appeal and supporting documentation directly to the QI Unit.

Formal Provider Appeal Process of a Formal Complaint

1. Provider may submit an appeal within 30 calendar days of written decision to the Formal Complaint.
2. Appeals from Children's Mental Health Services shall be submitted in writing to the Assistant Deputy Director of Children's Mental Health Services.
3. The Appeal Form shall summarize the issue(s) and outline support for appeal. Previous documents on the issue(s) shall be attached.
4. The ADD shall notify the provider, in writing, of the decision within 60 calendar days from the receipt of the appeal and supporting documents, using the Formal Appeal Response section of the Formal Complaint by Provider form.
5. The written response from the ADD shall include a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.
6. Formal Provider Appeal documentation is to be directed to:

Assistant Deputy Director of
Children's Mental Health Services
P.O. Box 85524
San Diego, CA 92186-5524
Mail Stop: P531-C

7. A copy of all appeals materials should be sent to the County Mental Health QI Unit:

Quality Improvement Unit
P.O. Box 85524
San Diego, CA 92186-5524
Fax: 619-584-5018
Mail Stop: P531-Q (Children)

Complaints and Appeals for Denial of Authorization or Payment for Services

Providers have the right to access the provider appeal process at any time before, during or after the provider problem resolution process has begun when the complaint concerns a denied or modified request for MHP authorization, a problem with processing of a payment, or a billing disallowance.

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PROVIDER ISSUE RESOLUTION

Providers appealing a denial of authorization or payment must submit a written complaint within 90 days of the receipt of the denial (30 days for a billing disallowance) to their County Regional Coordinator/Program Monitor. The written complaint should include the client name, MIS #, date of authorization/payment denial and/or dates of all service(s), along with any specific information relevant to the complaint. (See Authorization of Reimbursement for Services section of this Handbook for more information on denials.)

All such complaints will be logged and a response will be issued within 30 days about action or denial. At any time within 90 days of the original attempt to resolve the issue informally, providers may appeal any decision made by the Program Monitor by submitting an appeal to the County Mental Health Director or his designee. The appeal should include the client name, MIS #, date of authorization/payment denial and/or dates of all service(s) along with a copy of the Program Monitor's letter of response. The County Mental Health Director or his designee will have 30 days to make a final decision on the appeal and respond back in writing to the provider.

Contract Administration and Fiscal Issues with MHP Contracts

Please see the Provider Contracting section of this Handbook.